

RETURN DATE: APRIL 19, 2022

EDWARD PRATT

v.

JACC HEALTHCARE CENTER OF
NORWICH, LLC, JACC HEALTHCARE
GROUP, LLC, JACC MANAGEMENT, LLC

SUPERIOR COURT

J.D. OF NEW LONDON
AT NEW LONDON

MARCH 14, 2022

COMPLAINT

FIRST COUNT: (Gross medical negligence)

1. At all times mentioned herein, the Defendant, JACC Healthcare Center of Norwich, LLC a/k/a Three Rivers Nursing Home [hereinafter "Three Rivers"], was a limited liability corporation duly organized and existing under the laws of the State of Connecticut and engaged in the business of operating a duly accredited rehabilitation and nursing home, and held itself out to the general public as having at its disposal all reasonable, necessary, fit, and proper personnel, physicians, facilities, appointments, apparatuses, appliances, and surroundings; and, held itself out to the general public as being ready, willing and able to provide long-term rehabilitation and nursing home care and treatment to patients.

2. At all times mentioned herein, the Defendant, JACC Healthcare Group, LLC, [hereinafter "JACC Healthcare"], was and is a limited liability corporation organized and existing under the laws of the State of Connecticut comprised of doctors, nurses, and other healthcare professionals doing business at the Defendant Three Rivers in Norwich, Connecticut, and held itself out to the general public as being ready, willing, and able to provide rehabilitation and nursing home care and treatment to patients.

3. At all times mentioned herein, the Defendant, JACC Management, LLC, [hereinafter "JACC Management"], was and is a limited liability corporation organized and existing under the laws of the State of Connecticut, and owned, operated, managed, controlled, and/or was the licensee of the long-term skilled nursing care and rehabilitation facility commonly known as the Defendant, Three Rivers.

4. On or about January 24, 2020 through September 21, 2020, the Plaintiff, Edward Pratt, was an in-patient resident of the Defendant Three Rivers and was under the care and treatment of the Defendants Three Rivers, JACC Healthcare, and JACC Management for diabetes and a left lower extremity amputation.

5. In or about January 2020, and likely earlier, the Defendants were made aware of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) spreading

world-wide and nationally, known colloquially as the coronavirus, that caused severe medical distress and death in individuals who contracted the disease, especially the elderly and those with underlying medical conditions.

6. SARS-CoV-2 is known and documented to cause a debilitating and deadly disease, the Coronavirus Disease 2019 (hereinafter referred to as "COVID-19").

7. At all relevant times, the Defendants knew or should have known that residents like the Plaintiff, who have underlying medical conditions were at high risk for the contraction and transmission of respiratory illnesses and other viruses by means of respiratory droplets, including, but not limited to, different types of coronaviruses.

8. On March 10, 2020, the Governor of Connecticut, Ned Lamont, issued Executive Order No. 7, declaring COVID-19 a public health emergency.

9. On March 13, 2020, the Connecticut Commissioner of the Department of Public Health (DPH) issued an Executive Order that banned all visitors to skilled nursing home facilities and long-term resident facilities, such as the Defendant Three Rivers, to prevent the transmission of COVID-19 to vulnerable populations. The Order also mandated risk screenings and personal protective equipment for unavoidable visitors, such as law enforcement or service/maintenance providers.

10. On April 17, 2020, Governor Lamont issued Executive Order No. 7BB, which mandated cloth face coverings or a higher level of protection for individuals in public wherever close contact was unavoidable.

11. Shortly thereafter, the State of Connecticut Department of Public Health began conducting COVID-19 monitoring at nursing home facilities in an effort to prevent and control potential outbreaks of the disease in congregate settings.

12. On May 7, 2020, the Department of Public Health visited the Defendant Three Rivers to conduct a COVID-19 monitoring visit and found the facility failed to ensure effective infection prevention/control strategies were followed by staff members, including improper storage of liquid hand sanitizer supplies and failure to utilize the necessary personal protective equipment when caring for patients.

13. The DPH observed limited quantity of mounted liquid hand sanitizer dispensers, while the facility had ample supply of said sanitizer, an unsecured and opened liquid hand sanitizer bag on top of an isolation unit, staff members not utilizing personal protective equipment, and staff members not utilizing disinfectant on said personal protective equipment.

14. On June 17, 2020, Executive Order 7AAA signed by Governor Lamont went into effect that mandated COVID-19 testing of nursing home staff members on a weekly basis.

15. After Executive Order 7AAA was signed, the Defendants Three Rivers, JACC Healthcare and JACC Management failed to test 29% of their staff members for COVID-19, yet various residents at the Defendant Three Rivers were known or suspected to be positive for COVID-19.

16. On June 25, 2020, Executive Order 7BBB signed by Governor Lamont went into effect that mandated self-quarantines for a period of fourteen (14) days for residents of Connecticut that traveled out-of-state.

17. On July 24, 2020, a registered nurse and agent, apparent agent, servant, and/or employee of the Defendants worked at the Defendant Three Rivers while experiencing symptoms of COVID-19, without completing a mandatory quarantine for out-of-state travel, and after direct exposure to family members that potentially had COVID-19, thereby exposing various staff members and vulnerable residents to the disease.

18. At that time, the Defendants by and through their agents, apparent agents, servants, and/or employees failed to enforce Executive Order 7BBB and conduct mandatory screenings of their staff members to ensure they were not returning from out-of-state travel.

19. On July 27, 2020, said registered nurse tested positive for COVID-19 and subsequently a licensed practical nurse working with said registered nurse on July 24, 2020 tested positive.

20. Between July 27, 2020 through August 17, 2020, the Defendants by and through their agents, apparent agents, servants, and/or employees cohorted patients that were COVID-19 positive, negative, and under investigation in the same units and failed to maintain an accurate or current listing of each patient's COVID-19 status.

21. During this time period, agents, apparent agents, servants, and/or employees of the Defendants cared for and treated both COVID-19 positive and negative patients during the same shifts.

22. In August 2020, the Department of Public Health made a series of unannounced visits to the Defendant Three Rivers to conduct COVID-19 monitoring and

cited the nursing home for seven different violations of state law for failures related to the prevention and control of a COVID-19 outbreak.

23. On August 2, 2020, the first patient at the Defendant Three Rivers tested positive for COVID-19, and by August 15, 2020 the nursing home had ten positive cases.

24. On August 12, 2020, the Plaintiff began experiencing COVID-19 symptoms and subsequently tested positive for COVID-19 on August 15, 2020.

25. On August 15, 2020, the Plaintiff was transferred to nearby William Backus Hospital for COVID-19 and for dehydration. Further laboratory testing at Backus showed the Plaintiff's kidney function had significantly declined. The Plaintiff was subsequently treated with IV fluids and discharged back to the Defendant Three Rivers.

26. On August 17, 2020, the DPH learned that two units at the Defendant Three Rivers were grossly understaffed with one registered nurse and two nursing assistants to care for twenty residents.

27. On August 17, 2020, the Director of Nursing at the Defendant Three Rivers admitted to the DPH that she was unable to develop a plan for designating staff

members to care exclusively for COVID-19 positive residents, residents under investigation, or for negative residents due to understaffing by the Defendants JACC Healthcare and/or JACC Management.

28. She further admitted that she made JACC Healthcare and/or JACC Management acutely aware of the understaffing issue but she was not provided additional staffing.

29. The injuries and damages to the Plaintiff, Edward Pratt, were due to the gross negligence and reckless disregard for the safety of their patients, including the Plaintiff, by the Defendants, their agents, apparent agents, servants and/or employees, in one or more of the following respects, in that they:

- a. Failed to ensure appropriate cohorting of residents to prevent the transmission of COVID-19;
- b. Failed to utilize personal protective equipment in accordance with CDC standards;
- c. Failed to maintain an updated and accurate outbreak listing of COVID-19 status of residents;
- d. Failed to require a fourteen day quarantine for staff and residents with possible exposure or whose COVID-19 status was under investigation;

- e. Failed to adequately supervise nursing staff at the Defendant Three Rivers;
- f. Failed to utilize personal protective equipment in accordance with the Centers for Disease Prevention and Control standards by failing to ensure staff members wore masks;
- g. Failed to properly use personal protective equipment to prevent and stop the spread of COVID-19 to residents like the Plaintiff;
- h. Violated C.F.R. § 483.80 by failing to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of COVID-19;
- i. Violated C.F.R. § 483.80(a)(1) by failing to establish an infection prevention and control program (IPCP) that included a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, like the Plaintiff;
- j. Violated Executive Order No 7AAA and §§ 19-13-D8t(f)(3), 19-13-D8t(j)(2) of the Regulations of Connecticut State Agencies by failing to conduct staff testing for COVID19;
- k. Violated C.F.R. § 483.80(a)(2) by failing to establish a system of surveillance to identify communicable diseases or infections before they can spread to other persons in the facility;
- l. Violated C.F.R. § 483.10(a)(1) by failing to treat the Plaintiff with care that promoted maintenance or enhancement of his quality of life;

- m. Violated C.F.R. § 483.80(a)(2)(v), by failing to prohibit employees with a communicable disease from direct contact with residents;
- n. Violated §§ 19-13-D8t(h)(2)(B) and 19-13-D8t(j)(2) of the Regulations of Connecticut State Agencies by failing to assure quality medical care was provided to residents, like the Plaintiff;
- o. Violated § 19-13-D8t(k)(1) of the Regulations of Connecticut State Agencies by failing to adequately supervise nursing staff at the Defendant Three Rivers;
- p. Violated § 19-13-D8t(t)(1) of the Regulations of Connecticut State Agencies by failing to have an infection control committee;
- q. Violated § 19-13-D8t(t)(2) of the Regulations of Connecticut State Agencies by failing to have an infection prevention, surveillance, and control program, and policies and procedures for investigating, controlling, and preventing infections in the facility and recommendations to implement such policy;
- r. Failed to ensure that staff members followed Executive Order 7III and Connecticut Travel Advisories issued by the Connecticut Commissioner of Public Health that mandated self-quarantines for Connecticut residents returning from out-of-state;
- s. Failed to ensure the appropriate cohorting of residents to stop the prevent and transmission of COVID-19 to residents.
- t. Failed to established or maintained an infection prevention and control program designed to prevent the development and transmission of viral diseases, like COVID-19, as required by C.F.R. § 483.80, although the

Defendants knew of the dangers of COVID-19 to residents, like the Plaintiff;

- u. Failed to established or maintained an infection prevention and control program (IPCP) that included a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases, like COVID-19, as required by C.F.R. § 483.80(a)(1), although the Defendants knew of the dangers of COVID-19 to residents, like the Plaintiff;
- v. Failed to conduct mandatory staff testing for COVID-19, in violation of Executive Order No 7AAA and §§ 19-13-D8t(f)(3), 19-13-D8t(j)(2) of the Regulations of Connecticut State Agencies, although the Defendants knew of the importance of screening COVID-19 positive staff members from vulnerable residents, like the Plaintiff, in the facility;
- w. Failed to enforce mandated self-quarantines for staff members returning from out-of-state travel, in violation of followed Executive Order 7III and Connecticut Travel Advisories, when they of the dangers associated with allowing exposed staff members to have direct contact with vulnerable residents, like the Plaintiff;
- x. Failed to properly and adequately screen visitors and staff members from entering the building with appropriate out-of-state travel questions, in violation of Executive Order 7BBB, when they knew the dangers associated with allowing exposed staff members to have direct contact with vulnerable residents, like the Plaintiff;
- y. Allowed entry into the facility by an otherwise banned visitor, in violation of Executor Order by the Commissioner of the DPH, dated March 13, 2020, and knew that said visitor had direct contact with residents without the appropriate face covering and social distancing requirements, which

exposed said vulnerable residents, like the Plaintiff, to communicable diseases such as COVID-19;

- z. Cohorted residents together, regardless of their COVID-19 status, when they knew that direct contact with COVID-19 positive or suspected positive residents by other negative residents, would cause the infection to rapidly spread throughout the facility;
- aa. Failed to maintain an accurate, updated, or accessible list of the COVID-19 status of the residents in order to cohort them in the appropriate unit to prevent the continued spreading of COVID-19 to vulnerable residents, like the Plaintiff, when they knew that placing COVID-19 negative residents in direct contact with COVID-19 positive residents would cause an outbreak and potentially life-threatening conditions;
- bb. Knew of the health risks associated with contradicting COVID-19 by vulnerable populations and failed to ensure a fourteen (14) day quarantine was maintained for residents with possible exposure or whose COVID-19 status was under investigation, which caused the disease to spread across the facility to residents, like the Plaintiff;
- cc. Scheduled staff members to work with COVID-19 positive and COVID-19 negative residents in the same shift, although the Defendants knew or should have known of the dangers and risks associated with doing so, including to the Plaintiff;
- dd. Knew that staff members were not utilizing the appropriate personal protective equipment when in direct contact with residents and other staff members, which risked the health and safety of vulnerable residents, like the Plaintiff, and failed to correct said staff members;
- ee. Knew that the Plaintiff had the signs and symptoms of COVID-19, including cough shortness of breath, diarrhea, headache, and loss of

sense and smell, and had comorbidities but failed to provide any treatment for COVID-19 without regard for the dangers associated with untreated COVID-19; and

- ff. Knew it had inadequate staffing at the facility to meet the needs of the residents, like the Plaintiff, and continued to operate with inadequate staffing while the care and treatment of said residents, such as the Plaintiff, continued to suffer;

30. As a result of the gross negligence and reckless disregard for the safety of their patients by the Defendants, their agents, apparent agents, servants, and/or employees, the Plaintiff contracted COVID-19, pneumonia, shortness of breath, weakness, and permanent lung damage. The Plaintiff was further required to undergo multiple hospitalizations and medical treatment. The Plaintiff's injuries are likely permanent in nature and he will likely require additional medical care and treatment in the future. Furthermore, the Plaintiff suffered and will in the future continue to suffer great physical and mental pain, and has been and will in the future be unable to participate in many of the activities in which he engaged prior.

31. As a result of the gross negligence and reckless disregard for the safety of their patients by the Defendants, their agents, apparent agents, servants, and/or employees, the Plaintiff has been required to spend various sums of money for medical

care and treatment, rehabilitative care, drugs, and devices, all to his loss and damage, and will be required to spend additional sums in the future for his medical care.

32. As a result of the gross negligence and reckless disregard for the safety of their patients by the Defendants, their agents, apparent agents, servants, and/or employees, the Plaintiff was caused to suffer extreme pain, emotional anguish, and mental distress due to his COVID-19 illness, severe pneumonia, and subsequently permanent damage to his lungs.

33. As a further result of the gross negligence and reckless disregard for the safety of their patients by the Defendants, their agents, apparent agents, servants, and/or employees, the Plaintiff suffers an increased risk of future harm in that he has a greater susceptibility to further injury which may occur in the future along with accompanying anxiety and fear concerning the future in that regard.

SECOND COUNT: (Negligence)

1-28 Paragraphs One (1) through Twenty Eight (28) of the First Count are incorporated and hereby made Paragraphs One (1) through Twenty Eight (28) of this the Second Count as if more fully set forth herein.

29. The injuries and damages to the Plaintiff, Edward Pratt, were due to the negligence and carelessness by the Defendants, their agents, apparent agents, servants and/or employees, in one or more of the following respects, in that they:

- a. Failed to utilize personal protective equipment in accordance with best practices and CDC standards;
- b. Failed to require a fourteen day quarantine for staff and residents with possible exposure or whose COVID-19 status was under investigation;
- c. Failed to adequately supervise nursing staff at the Defendant Three Rivers;
- d. Failed to utilize personal protective equipment in accordance with the Centers for Disease Prevention and Control standards by failing to ensure staff members wore masks;
- e. Failed to conduct staff testing for COVID19;
- f. Failed to ensure that staff members followed Executive Order 7III and Connecticut Travel Advisories issued by the Connecticut Commissioner of Public Health that mandated self-quarantines for Connecticut residents returning from out-of-state;
- g. Failed to enforce mandated self-quarantines for staff members returning from out-of-state travel, in violation of followed Executive Order 7III and Connecticut Travel Advisories, when they of the dangers associated with allowing exposed staff members to have direct contact with vulnerable residents, like the Plaintiff;

- h. Failed to properly and adequately screen visitors and staff members from entering the building with appropriate out-of-state travel questions, in violation of Executive Order 7BBB, when they knew the dangers associated with allowing exposed staff members to have direct contact with vulnerable residents, like the Plaintiff;
- i. Allowed entry into the facility by an otherwise banned visitor, in violation of Executive Order by the Commissioner of the DPH, dated March 13, 2020, and knew that said visitor had direct contact with residents without the appropriate face covering and social distancing requirements, which exposed said vulnerable residents, like the Plaintiff, to communicable diseases such as COVID-19;
- j. Failed to maintain an accurate, updated, or accessible list of the COVID-19 status of the residents in order to cohort them in the appropriate unit to prevent the continued spreading of COVID-19 to vulnerable residents, like the Plaintiff, when they knew that placing COVID-19 negative residents in direct contact with COVID-19 positive residents would cause an outbreak and potentially life-threatening conditions;
- k. Scheduled staff members to work with COVID-19 positive and COVID-19 negative residents in the same shift, although the Defendants knew or should have known of the dangers and risks associated with doing so, including to the Plaintiff;
- l. Knew that staff members were not utilizing the appropriate personal protective equipment when in direct contact with residents and other staff members, which risked the health and safety of vulnerable residents, like the Plaintiff, and failed to correct said staff members;
- m. Violated § 19-13-D8t(t)(2) of the Regulations of Connecticut State Agencies by failing to have an infection prevention, surveillance, and control program, and policies and procedures for investigating, controlling,

and preventing infections in the facility and recommendations to implement such policy;

- n. Failed to ensure that staff members followed Executive Order 7III and Connecticut Travel Advisories issued by the Connecticut Commissioner of Public Health that mandated self-quarantines for residents returning from out-of-state travel;
- o. Failed to ensure the facility had appropriate out-of-state travel questions subject to Executive Order 7BBB, that screened visitors and staff members from entering the building that recently returned from out-of-state travel;
- p. Failed to ensure that employees properly wore facial coverings during their shifts;
- q. Failed to quarantine employees from the workplace that experienced signs and symptoms of COVID-19;
- r. Failed to establish proper cleaning measures of the facility such as routine cleaning and disinfecting of surfaces and equipment; and
- s. Failed to encourage workers to stay at home, if they were experiencing signs and symptoms of COVID-19.

30. As a result of the negligence of the Defendants, their agents, apparent agents, servants, and/or employees, the Plaintiff contradicted COVID-19, pneumonia, shortness of breath, weakness, and permanent lung damage. The Plaintiff was further required to undergo multiple hospitalizations and medical treatment. The Plaintiff's

injuries are likely permanent in nature and he will likely require additional medical care and treatment in the future. Furthermore, the Plaintiff suffered and will in the future continue to suffer great physical and mental pain, and has been and will in the future be unable to participate in many of the activities in which he engaged prior.

31. As a result of the negligence of the Defendants, their agents, apparent agents, servants, and/or employees, the Plaintiff has been required to spend various sums of money for medical care and treatment, rehabilitative care, drugs, and devices, all to his loss and damage, and will be required to spend additional sums in the future for his medical care.

32. As a result of the negligence of the Defendants, their agents, apparent agents, servants, and/or employees, the Plaintiff was caused to suffer extreme pain, emotional anguish, and mental distress due to his COVID-19 illness, severe pneumonia, and subsequently permanent damage to his lungs.

33. As a further result of the negligence of the Defendants, their agents, apparent agents, servants, and/or employees, the Plaintiff suffers an increased risk of future harm in that he has a greater susceptibility to further injury which may occur in the future along with accompanying anxiety and fear concerning the future in that

regard.

THIRD COUNT: (medical malpractice)

1. At all times mentioned herein, the Defendant, JACC Healthcare Center of Norwich, LLC a/k/a Three Rivers Nursing Home [hereinafter "Three Rivers"], was a limited liability corporation duly organized and existing under the laws of the State of Connecticut and engaged in the business of operating a duly accredited rehabilitation and nursing home, and held itself out to the general public as having at its disposal all reasonable, necessary, fit, and proper personnel, physicians, facilities, appointments, apparatuses, appliances, and surroundings; and, held itself out to the general public as being ready, willing and able to provide long-term rehabilitation and nursing home care and treatment to patients.

2. At all times mentioned herein, the Defendant, JACC Healthcare Group, LLC, [hereinafter "JACC Healthcare"], was and is a limited liability corporation organized and existing under the laws of the State of Connecticut comprised of doctors, nurses, and other healthcare professionals doing business at the Defendant Three Rivers in Norwich, Connecticut, and held itself out to the general public as being ready, willing, and able to provide rehabilitation and nursing home care and treatment to patients.

3. At all times mentioned herein, the Defendant, JACC Management, LLC, [hereinafter "JACC Management"], was and is a limited liability corporation organized and existing under the laws of the State of Connecticut, and owned, operated, managed, controlled, and/or was the licensee of the long-term skilled nursing care and rehabilitation facility commonly known as the Defendant, Three Rivers.

4. On or about January 24, 2020 through September 21, 2020, the Plaintiff, Edward Pratt, was an in-patient resident at the Defendant Three Rivers facility that was managed and staffed by the Defendants JACC Healthcare and JACC Management.

5. At all relevant times, the Plaintiff, Edward Pratt, had pre-existing medical conditions such as diabetes and heart disease.

6. On June 5, 2020, the Defendants by and through their agents, apparent agents, servants, and/or employees directed the Plaintiff to be treated with diuretic medications, which is well known by medical professionals to increase urine output.

7. On July 13, 2020, the Defendants by and through their agents, apparent agents, servants, and/or employees added an additional diuretic medication to the Plaintiff's care plan.

8. On July 24, 2020, a quarterly nutrition note identified that the Plaintiff had experienced a 2% weight loss in one month due to the diuretic medications and failed to identify hydration goals to meet the Plaintiff's body requirements.

9. On July 31, 2020, the Plaintiff's resident care plan was assessed and failed to include an intervention to monitor the Plaintiff for signs and symptoms of hyperglycemia, such as increased thirst and to encourage fluids.

10. On that same date, the Plaintiff complained of increased thirst and was transferred to nearby William Backus Hospital for IV fluids and was discharged back to the Defendant Three Rivers later that day.

11. From August 1, 2020 to August 15, 2020, the Defendants by and through their agents, apparent agents, servants, and/or employees failed to document the Plaintiff's fluid intake and one nurse's note indicated that the Plaintiff required additional fluids due to his laboratory results, which indicated he was dehydrated.

12. On August 5, 2020, the Plaintiff continued to complain of increased thirst to the agents, apparent agents, servants, and/or employees of the Defendants. He was not provided additional fluids.

13. The next day, the Plaintiff's care plan identified that he should be monitored for symptoms of hyperglycemia, such as increased thirst and that fluids should also be encouraged due to an alteration in nutrition related to a therapeutic diet. However, his clinical record demonstrates that his fluid intake was not monitored, his complaints of thirst were not satisfied, and fluids were not actively encouraged or provided to the Plaintiff.

14. On August 9, 2020, the Plaintiff had symptoms of burning with urination, headache, cough, and constipation and underwent laboratory testing at the Defendant Three Rivers. The results of the laboratory testing demonstrated that the Plaintiff's kidney function was declining in the presence of dehydration. His dehydration remained untreated.

15. On August 14, 2020, the Plaintiff complained of diarrhea which is well known amongst medical professionals to cause dehydration. The Plaintiff's fluid intake remained unmonitored by staff members agents, apparent agents, servants and/or employees of the Defendants.

16. On August 15, 2020, the Plaintiff complained of increased thirst to a staff member at the Defendant Three Rivers, as the facility was not providing him with a water pitcher to ensure adequate hydration.

17. On August 15, 2020, the Plaintiff was transferred to nearby William Backus Hospital for dehydration. Further laboratory testing at Backus showed the Plaintiff's kidney function had significantly declined. The Plaintiff was subsequently treated with IV fluids and discharged back to the Defendant Three Rivers.

18. Upon the Plaintiff's return from the hospital on August 15, 2020, no assessment of the Plaintiff's hydration status was conducted, no intake or outtake of fluids was monitored, and no care plan addressed the Plaintiff's increased risk for dehydration from recent diuretic treatment.

19. On August 17, 2020, the Plaintiff's condition had worsened with increased symptoms of weakness and dry mucus membranes. He was subsequently transferred to Backus Hospital for acute care.

20. The Plaintiff was admitted for acute renal failure. Laboratory testing at Backus Hospital demonstrated that the Plaintiff's kidney function had significantly worsened due to dehydration.

21. From August 12, 2020 through August 17, 2020 when the Plaintiff was readmitted to Backus Hospital, the Plaintiff's condition, including his dehydration was not assessed by a registered nurse.

22. The injuries and damages to the Plaintiff, Edward Pratt, were due to the negligence and carelessness by the Defendants, their agents, apparent agents, servants and/or employees, in one or more of the following respects, in that they:

- a. Violated § 19-13-D8t(f)(3)(A) and 19-13-D8t(q)(1) of the Regulations of Connecticut State Agencies by failing to provide the services of a dietician to meet the hydration needs of the Plaintiff and conduct dietary assessments;
- b. Violated § 19-13-D8t(q)(2) of the Regulations of Connecticut State Agencies by failing to provide a diet for the Plaintiff, based upon the current recommended dietary allowances of the Food and Nutrition Board of the National Academy of Sciences, National Research Counsel, adjusted for the age, sex, weight, physical activity, and therapeutic needs of the Plaintiff;
- c. Violated § 19-13-D8t(m)(2) of the Regulations of Connecticut State Agencies by failing to employ nursing staff in the number, qualifications, and experience to ensure that residents, like the Plaintiff, received treatment, medications, and nourishment as prescribed in their care plan;
- d. Failed to implement measures to protect the Plaintiff from dehydration resulting in two hospitalizations and acute renal failure;

- e. Ignored complaints of increased thirst from the Plaintiff who was at risk for dehydration due to diuretic medications and diarrhea;
- f. Failed to provide the Plaintiff with adequate water or other fluids so as to prevent his dehydration;
- g. Failed to timely and properly diagnose his dehydration and subsequent loss of kidney function; and
- h. Failed to ensure proper documentation of assessments of Plaintiff's nutrition and hydration were conducted after the Plaintiff's change in condition.

23. As a result of the negligence of the Defendants, their agents, apparent agents, servants, and/or employees, the Plaintiff suffered acute renal failure due to dehydration and permanent kidney damage. The Plaintiff was further required to undergo multiple hospitalizations and medical treatment. The Plaintiff's injuries are likely permanent in nature and he will likely require additional medical care and treatment in the future. Furthermore, the Plaintiff suffered and will in the future continue to suffer great physical and mental pain, and has been and will in the future be unable to participate in many of the activities in which he engaged prior.

24. As a result of the negligence of the Defendants, their agents, apparent agents, servants, and/or employees, the Plaintiff has been required to spend various

sums of money for medical care and treatment, rehabilitative care, drugs, and devices, all to his loss and damage, and will be required to spend additional sums in the future for his medical care.

25. As a result of the negligence of the Defendants, their agents, apparent agents, servants, and/or employees, the Plaintiff was caused to suffer extreme pain, emotional anguish, and mental distress and suffers an increased risk of future harm in that he has a greater susceptibility to further injury which may occur in the future along with accompanying anxiety and fear concerning the future in that regard.

WHEREFORE, the Plaintiff claims:

1. Fair, just and reasonable money damages;
2. Punitive damages; and
3. Whatever other relief the court may deem fair, just, and equitable.

THE PLAINTIFF,


By _____
Joseph M. Barnes, Esq.
THE REARDON LAW FIRM, P.C.
His Attorneys

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GROUP, LLC, JACC MANAGEMENT, LLC

SUPERIOR COURT

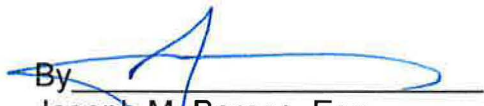
J.D. OF NEW LONDON
AT NEW LONDON

MARCH 14, 2022

STATEMENT OF AMOUNT IN DEMAND

The amount in demand is greater than Fifteen Thousand and No/100
(\$15,000.00) Dollars, exclusive of interest and costs, pursuant to Section 52-91 of the
Connecticut General Statutes.

THE PLAINTIFF,

By 
Joseph M. Barnes, Esq.
THE REARDON LAW FIRM, P.C.
His Attorneys

THE REARDON LAW FIRM, P.C.
Attorneys at Law

160 Hempstead Street • P.O. Drawer 1430 • New London, CT 06320 • Tel. (860) 442-0444 • Juris No. 102515

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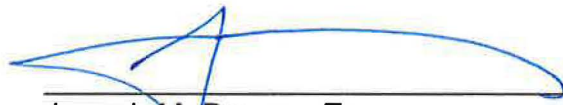
SUPERIOR COURT

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MARCH 14, 2022

CERTIFICATION

I hereby certify that I have made reasonable inquiry, as permitted by the circumstances, to determine whether there are grounds for a good faith belief that there has been negligence in the care and treatment of the Plaintiff. This inquiry has given rise to a good faith belief on my part that grounds exist for an action against each of the named defendants in this lawsuit. I base this belief, in part, on the written and signed medical opinion of a similar health care provider, attached hereto as Exhibits A and B in accordance with §52-190a of the Connecticut General Statutes (as amended).



Joseph M. Barnes, Esq.
Commissioner of the Superior Court

EXHIBIT A

SIMILAR HEALTH CARE PROVIDER'S OPINION

PURSUANT TO C.G.S. SECTION 52-190a

I am a Registered Nurse with experience practicing in a Skilled Nursing Facility setting and as a Director of Nursing. I am familiar with the standard of care as it related to the provision of nursing care in a Skilled Nursing Facility setting in the year 2020 in the United States and Connecticut.

I have reviewed the following documents:

- a. Three Rivers Healthcare Medical Record 1/24/20 – 9/21/20
- b. Backus Hospital Medical Record 8/15/20 – 8/15/20
- c. Backus Hospital Medical Record 8/17/20 – 8/24/20
- d. Department of Health and Human Services Statements of Deficiencies for:
 - 5/7/20
 - 8/19/20
 - 9/9/20
- e. Department of Public Health Directed Plan of Correction (DPOC) 9/10/20
- f. Department of Public Health Emergency Order 9/16/20

Based upon my review of the above, it is my opinion that there is evidence of breach of standard of care and gross negligence on the part of Three Rivers Healthcare and/or its agents/ apparent agents/ servants/ employees, in the care and treatment of Edward Pratt during the admission of 1/24/20 – 9/21/20 and that said breach of standard of care proximately caused Edward Pratt's diagnoses of dehydration, renal failure and COVID-19 virus. The basis for this opinion includes but is not limited to the following:

- 1. Edward Pratt was admitted as a short-term resident to Three Rivers with diagnoses that included traumatic right below the knee amputation, congestive heart failure and diabetes. Edward was independent with bed mobility, eating and personal hygiene. He required limited assistance of one staff person with walking and toilet use. Edward was assessed as having moderate cognitive impairment (BIMS score of 11) on 7/31/20.
- 2. On 1/24/20 Edward Pratt's initial interdisciplinary plan of care for nutritional status indicated to provide fluids as ordered and monitor intake and output. On 1/31/20, an additional interdisciplinary plan of care was created to address Edward Pratt's potential for alteration in nutrition risk. Interventions indicated to encourage fluids and intake.
- 3. There was failure to provide Edward with an interdisciplinary plan of care for risk of dehydration related to diuretic medication utilization and necessary interventions to prevent dehydration;

4. On 1/31/20, a hydration evaluation was completed by a Registered Dietician and indicated the Edward Pratt's daily fluid requirements were 2,490 milliliters.
5. Physician orders dated 6/4/20 – 7/12/20 directed treatment with diuretic medications of Spironolactone, Furosemide and Torsemide to manage Edward's congestive heart failure and body fluid overload. Diuretic drugs work within the system of the kidneys to filter fluids by pulling fluids out of the bloodstream resulting in increased urine output.
6. Quarterly nutrition note dated 7/24/20 by a Registered Dietitian indicated that Edward experienced a 2% desirable weight loss in one month related to diuretic therapy however the Registered Dietician failed to address Edward Pratt's fluid intake and daily fluid goals being met;
7. Review of medical record for 6/4/20 – 8/17/20 failed to provide documentation of Edward Pratt receiving intake and output monitoring or hydration assessment despite diuretic medication usage, risk for dehydration and laboratory values BUN/Creatinine increasing from his baseline;
8. On 8/9/20, there was failure to place Edward Pratt on intake and output monitoring despite physician order to encourage fluids due to a BUN 49 (range 6-20) and Creatinine 1.5 (range 0.7-1.5) which was a marked increase from Edward's baseline laboratory values of BUN ranging 36-39 and Creatinine ranging 0.9-1.0;
9. Nurse progress note dated 8/11/20 indicated Edward Pratt reported having diarrhea two times today and one time yesterday. Subsequent nurse progress note dated 8/12/20 indicated that Edward Pratt complained of sinus pressure, loss of taste, loss of appetite and diarrhea. Physician was notified with new order given for CBC, BMP, droplet/contact precautions and a COVID-19 swab.
10. Nurse progress note dated 8/14/20 indicated Edward Pratt complained of fatigue, nausea, loose stools two times, refusal of breakfast stating "I can't smell or taste". Edward further complained of chest tightness with shortness of breath. Physician was notified with new order to transfer to Backus Hospital ER.
11. Nurse progress notes dated 8/15/20 indicated that results from COVID-19 test 8/12/20 are positive. Further documentation indicates Edward returned from Hospital and that Edward and his wife are aware of COVID-19 diagnosis and were educated on precautions.
12. Documentation dated 8/15/20 from Backus Hospital indicated Edward requested to come to hospital for evaluation after one week of cough, shortness of breath, diarrhea, headache, loss of taste/smell, and reported not improving and today having chest pain. Further documentation revealed laboratory values of BUN 59 (range 8-21) and Creatinine 2.0 (range 0.5-1.3). Edward was provided intravenous fluids and diagnosed with

COVID-19 virus. According to Taber's Cyclopedic Medical Dictionary, the BUN and Creatine values provide an estimate of kidney function with high levels in the presence of dehydration.

13. On 8/15/20 – 8/17/20, there was failure to perform Registered Nurse assessments on Edward Pratt's hydration status and to implement intake and output monitoring following his return from the hospital receiving intravenous fluids for dehydration and failure to update Edward's interdisciplinary plan of care to address his increased risk for dehydration due to hospitalization, diarrhea and diuretic medication utilization to prevent further deterioration in his condition;
14. Nurse progress note dated 8/17/20 indicated Edward Pratt complained of chest tightness, dry mucous membranes, weakness, unable to get out of bed, hasn't eaten in seven days, unable to keep fluids down, vomiting bile two times this shift and appears pale. Reported to physician with new order to transfer to hospital.
15. Documentation dated 8/17/20 from Backus Hospital indicated that Edward's chest x-ray showed increased infiltrates concerning for covered disease (COVID-19) and that his kidney function has significantly declined in the past 48 hours. Intravenous fluids were ordered and Edward was being admitted to the hospital with diagnoses of COVID-19 with respiratory failure and increasing lung infiltrates and renal failure.
16. There was failure to perform Registered Nurse assessments on Edward Pratt from 8/9/20 – 8/17/20 despite Edward experiencing a change in condition with multiple documented episodes of diarrhea and complaints of not feeling well in conjunction with increasing laboratory values on 8/13/20 of BUN 55 (range 6-20) and Creatinine 1.9 (0.7-1.5) resulting in hospitalization on 8/17/20 – 8/24/20;
17. Review of Department of Public Health inspection report dated 9/9/20 revealed that on 8/18/20 residents were not being provided the benefit of water pitchers for hydration, that the water pitchers had been discarded and needed replacement and that a grievance had been filed due to the discontinuation of the water pitchers;

It is my opinion that Three Rivers Healthcare failed to ensure Edward Pratt's hydration needs and goals were assessed and that they failed to provide him with adequate hydration. These deviations in the standards of care proximately caused Edward Pratt to suffer a change in condition and subsequently require hospitalization in which he was diagnosed with acute kidney failure secondary to dehydration.

In addition, it is my opinion that Three Rivers Healthcare and/or its agents/ apparent agents/ servants/ employees, demonstrated gross negligence with respect to infection control and prevention practices that constituted a pattern of immediate jeopardy to the health and safety of its residents and the failure to prevent the transmission of COVID-19 in the following ways:

18. Review of Department of Public Health inspection dated 5/7/20, the facility demonstrated unsafe storage of hand sanitizer and a failure to utilize eye protection as part of the personal protective equipment required for the care of a resident on droplet transmission-based precautions which resulted in a deficiency of potential for harm.

19. Review of Department of Public Health inspection dated 8/19/20, the facility demonstrated a pattern of deficient infection control and prevention practices that constituted immediate jeopardy to the health and safety of the residents by:

- Failure to ensure appropriate cohorting of residents to prevent the transmission of COVID-19. First facility COVID-19 case 8/2/20 and per surveyor interview with Director of Nursing, no plan for three distinct units (positive, negative and those under investigation) due to lack of staff.
- Failure to ensure appropriate designation of staff. Per surveyor interview with Director of Nursing, unable to implement a plan for designating staff to care exclusively for COVID-19 positive, COVID-19 negative or residents whose status is under investigation due to lack of available staff.
- Failure to utilize personal protective equipment in accordance with CDC standards.
- Failure to maintain an updated, accurate or accessible outbreak listing of the COVID-19 status of the residents.
- Failure to ensure a required 14-day quarantine was maintained for a resident with possible exposure or whose COVID-19 status was under investigation.
- Failure to ensure that an aerosolized generating procedure medication was administered in a manner consistent with current infection control standards.
- Failure to ensure visitor screening regarding a person's recent travel history was conducted in accordance with executive order dated 6/25/20 by the Governor of the State of Connecticut.
- Failure to ensure appropriate storage of reusable gowns to maintain infection control standards.

20. Review of Department of Public Health inspection dated 9/9/20, was an extended inspection to determine compliance with regulatory requirements for Long Term Care Facilities including proper infection prevention and control practices to prevent the development and transmission of COVID-19 after previous inspection. The facility continued to demonstrate a pattern of deficient infection control and prevention practices by:

- Failure to promptly implement necessary transmission-based precautions.
- Failure to relocate and cohort residents to a unit designated for persons under investigation for COVID-19 at the time the resident exhibited the symptoms.
- Failure to conduct a risk assessment for the use of face masks or implement alternate measures to promote infection control.
- Failure to ensure staff were fit tested for N95 masks or staff trained to ensure appropriate seal when wearing an N95 mask.

- Failure to properly use personal protective equipment and to appropriately perform hand hygiene.
- Failure to store soiled linen on an exposed COVID-19 unit in accordance with infection control standards of practice.
- Failure to ensure screening was completed for COVID-19 for visitors.
- Failure to ensure dietary services sanitation on COVID-19 positive unit and environmental services disinfection was provided in accordance with infection control standards of practice.
- Failed to conduct staff testing in accordance with executive order 7AAA stating beginning 6/14/20 mandatory weekly COVID-19 testing for staff of private and municipal nursing homes. Surveyor review of staff timecards for 55 employees identified 16 employees (29%) missed weekly testing.

21. Review of Department of Public Health Directed Plan of Correction (DPOC) dated 9/10/21, it was determined by the Department that an Independent Nurse Consultant would be required in the facility as well as an immediate Temporary Manager to provide complete facility oversight and operations.

22. Review of Department of Public Health Emergency Order Pursuant to Connecticut General Statute 19a-534a dated 9/16/20, it was determined the following:

- On August 24, 2020, the Department issued a Directed Plan of Correction ("DPOC") which among other things, ordered the facility to cease all admissions and hire an Independent Nurse Consultant; and,
- After an extended survey conducted on September 9, 2020, the Department issued an Amended Directed Plan of Correction ("Amended DPOC") on September 10, 2020, which, among other things, increased the hours of the Independent Nurse Consultant, and in which the facility was required to contract with a Temporary Manager who possessed broad duties to oversee and control all operations of the facility; and,
- On September 13, 2020, the Independent Nurse Consultant reported serious continued failures in infection control and prevention practices by the facility and its staff; and,
- The Temporary Manager has reported that there have been five COVID-19 related deaths in the facility, and there are 17 residents who remain in isolation for COVID-19 infections, and there are seven residents quarantined for observation for the development of COVID-19; and,
- On September 15, 2020, the Temporary Manager filed a report which identified widespread facility problems in its performance of basic care delivery obligations; and,
- The Temporary Manager concluded that the facility's inability to comply with the Amended DPOC and other state and federal requirements presented a meaningful risk of harm to the facility's residents.

- The Temporary Manager's report demonstrated serious deficiencies at the facility including deterioration of systems of accountability, staff education, the absence of controls and the absence of necessary staff which may result in serious harm to the residents and concludes that the facility cannot be brought into compliance with regulatory requirements by the time permitted under federal law and the Department's Order; and,
- Whereas, the Department makes the allegations contained in the Statement of Charges dated September 15, 2020,
- Whereas, the Commissioner finds that violations of the Regulations of Connecticut State Agencies have occurred and are occurring at the facility:
- Whereas, based on the foregoing, the Commissioner finds that the health, safety, and welfare of patients in the facility imperatively requires emergency action.
- Therefore, pursuant to the authority provided by the Connecticut General Statutes 19a-534a, the Commissioner ORDERS that the Licensee take the following actions:

As soon as possible considering all relevant circumstances, and in consultation with the Department and under the direction and authority of the Temporary Manager, discharge all patients to appropriate licensed facilities or other appropriate locations.

It is further my opinion that these continued deficient infection control and prevention practices by Three Rivers Healthcare and/or its agents/ apparent agents/ servants/ employees demonstrates reckless disregard for the reasonable treatment and safety of the residents at the facility, led to unnecessary transmission of COVID-19 to the residents and proximately resulted in Edward Pratt's diagnosis of COVID-19 and sequelae. The opinion stated herein is based upon my years of experience, education, training and the information available to me at this time. Should other information and evidence become available, I reserve the right to supplement and/or amend this opinion.

EXHIBIT B

Kelly Reardon, Esquire
THE REARDON LAW FIRM, P.C.
150 Hempstead Street
New London, Connecticut 06320

Dear Ms. Reardon:

You requested that I provide a letter of my preliminary expert opinions regarding the extent to which management and administrative standards of care were breached by THREE RIVERS HEALTH CARE of Norwich, Connecticut. In particular, I offer testimony as to the extent that THREE RIVERS was non-compliant with Federal and Connecticut regulations and standards as well as policies, practices and procedures relevant to this case that impacted the quality of life and the provision of quality care for Mr. Edward Pratt (and potentially other residents and patients of said facility).

Qualifications

I am the founder of _____ a consulting firm serving the senior/long term care field. At the end of 2013, I left the position of President and Chief Executive Officer of _____ a 160 bed, not-for-profit, skilled nursing facility located in _____. _____ after over 16 years in that role. I continue to practice as an interim executive to complement and supplement my expert witness and consulting practice, and am active in professional and trade associations. My consulting practice has included assignments with facilities, corporations, other consulting firms, vendors and academic institutions. I hold an M.A. in Health Care Administration from _____ University and am a veteran leader with more than 45 years in the

healthcare field. My expertise includes interim executive assignments, operational and compliance management, turnarounds, fund raising, marketing, and business/referral development. I have held a nursing home administrator's license since 1979 and have been a member of the American College of Health Care Administrators (ACHCA) for over 40 years. I achieved and maintained Fellowship and Nursing Home Administrator Certification status with ACHCA. I served on their national Board of Directors from 2001-2004 and am a past president of the Board of the Chapter. I have also served on the boards of several organizations, including the chapter of Leading Age, which represents over 30,000 nonprofit senior care organizations in the United States. Currently, I am the president of the Board of Directors of the Advocates for Nursing Home Reform. I have substantial experience as an executive, speaker, teacher, mentor, consultant, expert witness, author, and volunteer.

Materials Received and/or Reviewed (including but not limited to):

- Connecticut Department of Public Health survey information
- Medical Chart, Three Rivers Healthcare, Bacchus Hospital

Three Rivers Healthcare Center, a skilled nursing facility with 102 certified beds located in Norwich, Connecticut, was closed by the Connecticut Department of Public Health in 2020. Upon review of Connecticut Department of Public Health surveys there were severe deviations related to regulatory issues as well as non-compliance with standard operating procedures especially related to COVID 19, that resulted in gross negligence, violations of resident rights, staffing issues, and other deviations from the standard of care. In 2019, the facility was rated "below average" by the Federal government in providing quality care and regulatory compliance, as compared to other facilities in Connecticut and nationally. By virtue of the results of surveys by the Department of Public Health in 2020, the facility's ability to comply with regulations dramatically decreased from 2019. Therefore, based upon my initial review of available documents listed above as well as my knowledge of and experience in the field, it is my opinion that

Three Rivers deviated from the standard of care for a skilled nursing facility, which is validated by these violations of Federal (and Connecticut) regulations, lack of adherence to appropriate practices and policies, as well as other compliance and management issues. It is important to note that Connecticut regulations parrot the Federal regulations. These deviations from the standard of care and non-compliant behaviors resulted in negative outcomes to Mr. Pratt (and potentially others), as discussed in the next paragraphs.

All my opinions are given to a reasonable degree of administrative and management certainty. As this letter reflects a preliminary review of available documents, I reserve the right to change and amend these opinions as further information is obtained.

Mr. Pratt was first admitted to Three Rivers on January 24, 2020 for rehabilitation after an amputation at Bacchus Hospital. Unfortunately, in August, he contracted COVID 19 at Three Rivers, which not only prevented him from returned home as planned but also accelerated the deterioration of his condition, impacting the quality of his life. Frankly, by August, Three Rivers staff should have been enlightened and sensitized to COVID-related policies, practices and procedures, and there is overwhelming evidence that they were not aware of what was required to maintain a safe environment.

- **RESIDENT RIGHTS:** *Federal regulation 42 C.F.R. §483.10 states that "The resident has a right to a safe, clean, comfortable and homelike environment..." Additionally, the regulation states that the resident has the right "to receive services and/or items in accordance with the plan of care."* The facility failed to maintain a safe environment as a result of the fact that Mr. Pratt contracted COVID 19 at Three Rivers because of the gross negligence of the staff, as evidenced by the deficiencies with a high degree of severity cited by the Connecticut Department of Public Health, especially in infection control. These citations were noted during compliance surveys held during the Pandemic, one of which was an "extended" survey ordered by the Department of Public Health, reflecting the extent of Three River's deficient practice.

- **ABUSE, NEGLECT AND MISTREATMENT:** *Federal regulation 42 C.F.R. §483.13 states that residents have the right to be free of abuse, neglect and mistreatment, and a facility must provide policies, procedures, and practices to prevent abuse, mistreatment and neglect of its residents and must not only have mechanisms to train staff, but also must, in a timely fashion report and investigate allegations appropriate to this and other regulations.* As a result of the neglect and mistreatment of Mr. Pratt as presented in this report, (especially during the pandemic, as validated by the findings of the Connecticut Department of Public Health when they surveyed and resurveyed in 2020, the facility did not adhere to the regulations as stated, and deviated from the standard of care based on this and other compliance issues.
- **QUALITY OF CARE:** *The Federal regulation referring to and establishing the standard of care regarding the quality of care for residents of facilities is as follows: "Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care" (42 C.F.R. §483.25).* The facility was not able to maintain the highest practicable well-being due to gross neglect and mistreatment as highlighted in this report. As was stated in the previous paragraphs, the staff deviated from the standard of care in that the necessary care and services were not provided to the extent that his highest attainable well-being was not achieved. In fact, he remained in the facility for an extended period and was unnecessarily hospitalized for COVID 19 acquired at Three Rivers
- **QUALITY OF LIFE:** *Federal regulation 42 C.F.R. §483.15 states that "a facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life."* The facility did not promote or enhance Mr. Pratt's quality of life, as evidenced by the resultant accelerated deterioration, as well as quality of care issues noted in other sections of this report. The facility did not enhance or even maintain Mr. Pratt's quality of life by virtue of the continued worsening of his condition from COVID.

- **INFECTION CONTROL (42 C.F.R. §483.65):** *"The facility must establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection."* By virtue of the scope and severity of the results of the Connecticut Department of Public Health surveys during 2020, Three Rivers was out of compliance with the most basic aspects of infection control compliance as related to COVID 19 as well as other regulations as cited in this letter. Also, it deserves mention that the facility was cited for infection control issues by the Connecticut Department of Health in 2019. Quality leadership on a corporate level as well as appropriate day to day management and supervision should have ensured that the 2019 citation for infection control was not repeated. When facilities are cited in a survey, the facility administrator is required to submit a plan of correction. The Department of Public Health reviews and approves the plan. With this compliance history regarding infection control, one would think that staff would be particularly determined to provide the best possible infection control, another reflection of poor leadership and complacency. Coincidentally, In November of 2019, the Federal government rolled out enhanced infection control regulations. The requirements stipulated that a facility "must designate one or more individual(s) as the infection preventionist." This regulation also states that the designated party must have specialized infection prevention training and work at least part-time at the facility. The regulation was effective in November 2019 just months prior to the COVID-19 pandemic. Thus, prior to the pandemic, nursing facilities were mandated to have robust infection control programs, and clearly, Therefore, Three Rivers failed to maintain infection control regulations as mandated by the Federal government and validated by the 2020 surveys.
- **STAFFING:** *To be compliant with Federal regulation 42 C.F.R. §483.30(a), regarding staffing, a facility must provide a sufficient number of licensed staff and other nursing personnel to meet the needs of the residents and patients.* Nursing staff are the primary care providers and since nursing home residents depend on these people for their quality of life and quality of care, their jobs are never

ending and there never seems to be enough staff to do all that must be and should be done under normal circumstance. Thus, under circumstances where the staffing is short, nursing staff is forced to work harder, faster and under stress to the point where they may not necessarily spend the necessary time to do the tasks that are required to provide the necessary care for those residents for which the facility is responsible. Sufficient and appropriately trained staff would, in all likelihood, have prevented the COVID infection (e.g., he was placed in a room with a COVID positive resident), and taken the appropriate action to prevent the infection that accelerated Mr. Pratt's deterioration. Unfortunately, the existing staff exhibited a culture of complacency which further diminished the overall quality of care, which reflected poorly on the quality of administration and the support of ownership.

- **MEDICAL RECORDS:** *Federal (and state) regulations require that records are complete and accurate (42 C.F.R. §483.75).* Medical records were not complete as there were apparent gaps and omissions in Mr. Pratt's medical records. Standard facility medical records policies require that observations, medications administered, services performed, etc., must be documented in the resident's clinical record. Thus, based on an initial review of the medical chart, the facility was not only out of compliance with this regulation but also did not adhere to the standard medical record policy for skilled nursing facilities.
- **PROFESSIONAL SERVICES:** *Regarding Professional Standards, "the services provided or arranged by the facility must meet professional standards of quality..."; as defined in Federal regulation 42 C.F.R. §483.20(k).* The evident complacency and lack of professional dedication of the nursing staff in caring for Mr. Pratt as reflected in this report, indicates that the staff was not in compliance with this regulation. For example, in spite of the COVID crisis, staff did not follow infection control procedures, especially as related to COVID as validated in surveys. Although in-service education documentation was not provided, in all probability, staff training may have addressed these and other issues and prevented the negative impact on Mr. Pratt's quality of care and quality of life.

- **POLICIES AND PROCEDURES** represent the facility standard of care and are based on regulatory requirements. It is reasonable to assume that Three Rivers did not adhere to their own standard of care, especially those based on COVID related regulations, due to the citations from the 2020 surveys as discussed.
- **ADMINISTRATION:** *Federal regulation 42 C.F.R. §483.75(d) indicates that the administrator is "responsible for the management of the facility";* the typical job description for an administrator indicates that the administrator is responsible for compliance with all applicable laws as well as instituting systems, policies, and procedures to insure compliance. Fulfilling these responsibilities requires, for example, the monitoring of the quantity, quality and training of staff; developing a working atmosphere conducive to pro-active approaches to care (instead of complacency); enforcing policies and procedures; and providing oversight to programs and practices. Based on the above, the administrator did not adhere to this standard of care and practice, as there are numerous regulatory violations regarding the negligent care provided to Mr. Pratt.
- **GOVERNING BODY:** *Federal regulation 42 CFR §483.70(d)(1) indicates that a facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.* Based upon available documentation, there is no evidence to indicate that a governing body existed. A governing body would have fulfilled its regulatory responsibility and insured that Three Rivers was in compliance with Federal and State regulations, especially as related to COVID 19. There were numerous memos, regulatory changes, and other communication from the Federal government (e.g., CMS, the Center for Medicare and Medicaid, and CDC, the Center for Disease Control). so that Three Rivers staff should have been able to implement appropriate policies and procedures and adhere to the standard of care. Instead, and as validated by surveys, the complacency and incompetence of the staff in not being able to provide a safe environment and quality care caused Mr. Pratt, as well as others to suffer needlessly.

- **FINANCIAL ISSUES** – In reviewing the Medicare Cost Report for 2019 (2020 report not available at this writing), JACC Health Care Group, owners/operators of Three Rivers, charged \$178,437 in “management fees” to Three Rivers. Such fees would need to be analyzed to determine the extent to which management services contributed to the operation of the facility or were simply diverted to ownership with no regard for appropriate allocation of resources to direct care of Mr. Pratt and other residents.

CONCLUSION

In summary, based upon my preliminary review of relevant documents, it is my opinion to a reasonable degree of management and strict administrative certainty, that Three Rivers failed to adhere to the standard of care due to the failures of the facility to provide sufficient and comprehensive quality care to Mr. Pratt as mandated by Federal and Connecticut regulations. Therefore, Mr. Pratt suffered from facility acquired conditions (e.g., COVID) that were allowed to worsen due to gross neglect and mistreatment, contributing to his accelerated deterioration and unnecessary hospitalizations. There is ample evidence that the Three Rivers staff and corporate management was incapable if not incompetent to provide a safe environment and could not follow guidelines, recommendations and regulations from the Center for Disease Control as well as other agencies. Therefore, the facility staff did not adhere to Federal and Connecticut regulations, professional standards and common practices, thus deviating from the standard of care.

These initial findings are based on my knowledge and experience and are supported by a reasonable degree of certainty. I reserve the right to amend or supplement this report, as additional information is made available.